Providence | Providence SWEDISH

North Division Practice Alert

Revision to Therapy Notes

Intended Audience

- Therapists (PT, OT, SLP)
- Care Managers
- Providers
- Nurses

Why are we creating this practice alert?

To ensure patients are getting the right level of care, in the right place, at the right time, and to improve utilization and expenditure of post-acute care services, interdisciplinary team members need to consider, "Why not home?" when planning for patient discharge.

The "Why Not Home?" initiative promises to improve efficiency of care transitions by encouraging the care team to determine the least restrictive level of care and wraparound services clinically appropriate and available for each patient's needs. To support this initiative, therapists will explicitly outline their assessments of patient needs in the therapy note to help identify more options for patients. Care managers will be able to match therapist needs assessment to best resources available and acceptable to the patient and family.

What is changing?

The therapy note template in Epic has been revised. Instead of naming a particular discharge disposition in the therapy note, therapists will document their clear input on post-acute level of therapy, equipment, and any other therapy related needs. This will include an emphasis on what kind of support the patient needs versus, for example, the amount of hours care is needed.

Care managers will use the recommendations and supportive documentation in the therapy note along with patient and family preferences, and available care resources to identify the next site of care options for the patient.

Physicians, APCs, nurses, and other care team members can use case management and therapy documentation to inform decisions for next site of care.

What we need from you:

- Thoughtfully engage in asking, "Why not home?" to best support the patient's transition of care.
- Review education content and job aids intended to support and explain the changes to the therapy note.

Preview & Launch

- See image on right for an example of the revised therapy note prompts.
- The notes will launch in June.

Resources

- A job aid and examples have been created to help understand the "Indicators for Next Site of Care" to be found in the revised therapy note. (Attached)

Therapy Plan of Care

Next site of Care Therapy Recommendations:

Support Needed:

Barriers to Next Site of Care:

Equipment Recommendations:

AM-PAC Score:

Clinical Summary/Assessment:

Job Aid Instructions: Using Therapy Notes in Identifying Next Site of Care

This job aid is a guide to identifying key information within therapy notes useful in determining next site of care. Within each common disposition column, specific documentation phrases indicative of the disposition are highlighted (intensity, frequency), and additional considerations and information (patient factors, step down options) are called out according to the topic for each row in the grid.

Columns for common dispositions with reminder notes

Rows with specific documentation phrases in therapy note

Indicators for Next Site of Care

	IRF / ARU	SNF / Swing Bed	Home Health	Outpatient
	• Requires chart note with IRF recommendation • 2 or more discplines in any combination (PT, OT, SLP)	• Must have the need for daily skilled therapy ongoing low intensity therapy (frequency is pt dependent) • 1 discipline required in addition to nursing or with another therapy	• No prior authorization, treatment, or documentation required to order • OT cannot be only ordered therapy	• Will need provider referal
Intenstity *high / low* Therapy Note	• Ongoing high intensity therapy	• Ongoing low intensity therapy	• Home Health	• Outpatient
Frequency *hours / days* Therapy Note	• Able to tolerate 3 hrs per day • Minimum of 5 days therapy	• Minimum of 5 days of therapy	• HH therapist will evaluate	• OP therapist will evaluate
Patient Factors Care Management	• Patient and family in alignment with plan of care? • Needs are for skilled rehab • Patient choice given • Will insurance cover? • Follow IRF referral process	• Patient and family in alignment with plan of care? • Needs are for skilled rehab • Patient choice given	• Consider additional caregiving / equipment needs for home environment safety • Is patient homebound? • Patient choice given	• Consider additional caregiving / equipment needs for home environment safety
Step Down Options Care Management	• SNF apy) ed apy* ative n	• Option 1: In home setting with HH • Option 2: Community setting with HH ** Consider need for increased caregiving in either setting*		

Rows with considerations & information for care managers and team

NOTE:

- Use intensity and frequency criteria along with attention to the notes in the "Support Needed" and "Barriers to Next Site of Care" sections of the Therapy Plan of Care note in the EMR to support discharge planning.
- If step down option is necessary, advise care team asap to determine family training needs and / or coordination for ordering equipment.

Indicators for Next Site of Care

	IRF / ARU	SNF / Swing Bed	Home Health	Outpatient
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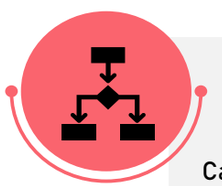 Step Down Options Care Management	• Option 1: SNF (daily skilled therapy) • Option 2: Increased caregiving & HH therapy* ** May consider alternative home program*	• Option 1: In home setting with HH • Option 2: Community setting with HH ** Consider need for increased caregiving in either setting*		

NOTE:

- Use intensity and frequency criteria along with attention to the notes in the "Support Needed" and "Barriers to Next Site of Care" sections of the Therapy Plan of Care note in the EMR to support discharge planning.
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Indicators for Next Site of Care

	IRF / ARU	SNF / Swing Bed	Home Health	Outpatient
	1 • Requires chart note with IRF recommendation • 2 or more discplines in any combination (PT, OT, SLP)	• Must have the need for daily skilled therapy ongoing low intensity therapy (frequency is pt dependent) • 1 discipline required in addition to nursing or with another therapy	• No prior authorization, treatment, or documentation required to order • OT cannot be only ordered therapy	• Will need provider referal
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Frequency *hours / days* Therapy Note	3 • Able to tolerate 3 hrs per day • Minimum of 5 days therapy	• Minimum of 5 days of therapy	• HH therapist will evaluate	• OP therapist will evaluate
Patient Factors Care Management	4 • Patient and family in alignment with plan of care? • Needs are for skilled rehab • Patient choice given • Will insurance cover? • Follow IRF referral process	• Patient and family in alignment with plan of care? • Needs are for skilled rehab • Patient choice given	• Consider additional caregiving / equipment needs for home environment safety • Is patient homebound? • Patient choice given	• Consider additional caregiving / equipment needs for home environment safety
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NOTE:

- Use intensity and frequency criteria along with attention to the notes in the "Support Needed" and "Barriers to Next Site of Care" sections of the Therapy Plan of Care note in the EMR to support discharge planning.
- If step down option is necessary, advise care team asap to determine family training needs and / or coordination for ordering equipment.

Sample Therapy Note:

Physical Therapy Plan of Care
Treatment (4/02) Note

Next Site of Care Therapy Recommendations: IRF ongoing high intensity therapy, able to tolerate 3 hours of therapy/day, pt is motivated participant, minimum 5 days of therapy/week, family involved/supportive, will benefit from structured setting

Support Needed: needs assist with all mobility/transfers

Barrier(s) to Next Site of Care: therapy goals not met, caregiver training not completed, physical assist needs exceed what caregivers can provide at this time

Equipment Recommendation(s): tilt in space wheelchair

AM-PAC Score: 8, score of 8 indicates 86.62% functional impairment with mobility

Clinical Summary/Assessment: The patient is far below their baseline functional level. They are making slow progress towards their goals. They will require ongoing skilled PT to maximize independence and worked towards the goals listed below.

Determining Next Site of Care

- As required for referral, the therapy note specifically indicates IRF/ARU (1) as the recommendation for next site of care in addition to the key indicators for intensity and frequency (2, 3).
- Disciplines: 2+ are required for IRF/ARU. PT is indicated (1) as this is a PT note. Review other therapy notes for additional disciplines.
- For IRF/ARU placements, patient and family willingness as well as whether insurance will cover are factors to consider. Follow your facility's referral process as promptly as possible should an alternative option be needed.
- If, for whatever reason, IRF/ARU is not an option for the patient, consider suggested step-down options (5). Note describes additional detail regarding what type of assistance is to be sought for next site of care (6).

Indicators for Next Site of Care

	IRF / ARU	SNF / Swing Bed	Home Health	Outpatient
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Sample Therapy Note:

Occupational Therapy Plan of Care
Treatment (4/02)

Next site of Care Therapy Recommendations: low intensity therapy (2), minimum 5 therapy days/week (3), will benefit from structured setting (4)

Support Needed: dependent mobility, needs assist for all BADLs and IADLs; needs meds managed (1) (dtr was providing assist) (6)

Barriers to Next Site of Care: cognitive impairment, fall risk, lack of equipment, level of assistance for ADL/Mobility, ongoing medical issues, physical impairment, OT goals for safe discharge not met

Equipment Recommendations: TBD (4)

AM-PAC Score: 6; 100% functional impairment

Clinical Summary/Assessment: Pt is FAR BELOW his functional baseline currently limited primarily by arousal, attention, and cognition, functional endurance/activity tolerance, gait, locomotion, and balance, neuromotor, visual/perceptual impairments.

Determining Next Site of Care

- This OT therapy note indicates low intensity therapy (2) and minimum of 5 days of therapy, indicative of SNF level services. There is also an indication in Support Needed section for medication management (1).
- If for this particular patient and their unique circumstances, a SNF is not an option, consider suggested stepdown alternatives (5) as well as other ideas to optimize assistance to the patient to meet the needs described (6). For other options, there may need to be additional caregiving support and/or equipment needs (4). If an alternative is needed, contact therapies. TBD recommendations (4) will be assessed according to next site of care, either at that site or by suggestion from inpatient therapies.

Indicators for Next Site of Care

	IRF / ARU	SNF / Swing Bed	Home Health	Outpatient
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NOTE:
- Use intensity and frequency criteria along with attention to the notes in the "Support Needed" and "Barriers to Next Site of Care" sections of the Therapy Plan of Care note in the EMR to support discharge planning.
- If step down option is necessary, advise care team asap to determine family training needs and / or coordination for ordering equipment.

Sample Therapy Note:

Physical Therapy Plan of Care
Initial Evaluation, Discharge (4/02)

Next site of Care Therapy Recommendations: Home Health PT (2) (1)

(4) **Support Needed**: daytime assistance needed for all out of bed mobility, transfers, and BADLs. Will benefit from a structured setting w/ a consistent plan for OOB mobility multiple times throughout the day. She'll need increased caregiver support needed and someone to hold her accountable for progressive increase in daily activity.

Barriers to Next Site of Care: increased caregiver assistance

Equipment Recommendations: bariatric bedside commode (has wheelchair) (4)

AM-PAC Score: 10, score of 10 indicates 76.75% functional impairment with mobility

Clinical Summary/Assessment: Patient is at/near their functional baseline; no further acute care PT needed.

Determining Next Site of Care

- The therapy note indicates "Home Health" (2) with the suggested discipline (1). A suggested frequency and intensity is not provided since the Home Health team will perform their own assessment (3).
- A location for Home Health care is not listed as the options may vary. The objective is to optimize assistance for the particular patient with their unique circumstances (4) *to include Home Health services*. Including, for example, home with more caregivers, AFH, community setting, etc.
- Take note of documentation indicating that even with home discharge and HH services, there may still need to be additional caregiving support and/or equipment needs (4).